

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 2 - 2 6

2. STATE:

Missouri3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

December 1, 2002TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ 0b. FFY 2003 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B Pages 1b, 1c, 2 and
Appendix A Pages 1 and 39. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Attachment 4.19B Pages 1b, 2 and
Appendix A Pages 1 and 3

10. SUBJECT OF AMENDMENT: This amendment will exclude nominal charge hospital providers from the outpatient prospective payment system and allow hospitals which changed ownership between January 1, 1997 and June 30, 2002 to be phased into the outpatient prospective payment system based on its actual cost history, if it requests.

11. GOVERNOR'S REVIEW (Check One):

- ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT *ce*
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:Missouri (02-26)

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Dana Katherine Martin

14. TITLE:

Director

15. DATE SUBMITTED:

12/13/02

16. RETURN TO:

approved: 02/27/03
effective: 12/01/02**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

12/17/02

18. DATE APPROVED

FEB 27 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

12/01/02

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Thomas W. Lenz

22. TITLE:

ARA for Medicaid & Children's Health

23. REMARKS:

cc:
Renne
Vadner
Waite
CO
DSG/DIATA

SPA CONTROL

Date Submitted: 12/13/02
Date Received: 12/17/02

STATE: Missouri

OPTOMETRIC SERVICES

The state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the Division of Medical Services. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods as expressed in 42 CFR 447 Subpart D. Agency payment will be the lower of :

- (1) The provider's actual charge for the service; or
- (2) The allowable fee based on reasonable charge as above determined.

The state agency will reimburse providers of any Optometric Services a may be covered under Medicare Part B, to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

- I Prospective Outpatient Hospital Services Reimbursement methodology for Hospitals Located Within Missouri.
 - A Outpatient hospital services shall be reimbursed on a prospective outpatient payment percentage effective July 1, 2002 except for services identified in subsection I.C. The prospective outpatient payment percentage will be calculated using the Medicaid overall outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003, the fourth, fifth and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998, and 1999.) The prospective outpatient payment percentage shall not exceed one hundred percent (100%) and shall not be less than twenty percent (20%).
 - B Outpatient cost-to-charge ratios will be as determined in the desk review of the base year cost reports.
 - C Outpatient hospital services reimbursement limited by rule.
 1. All services provided to General Relief (GR) recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-15.020.
 2. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.
 3. Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on a CMS-1500 professional claim form, which is incorporated by reference as part of this rule, and reimbursed from a Medicaid fee schedule or the billed charge, if less.
 4. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

- II Exempt Hospitals. Exempt Hospital Outpatient payment percent will be set as follows and will include:
- A New Medicaid providers which do not have a fourth, fifth and sixth prior year cost report.
1. Interim payment percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three state fiscal years in which the hospital operates. The cost reports for these years will have a cost settlement calculated in accordance with Attachment 4.19B Appendix A.
 2. Outpatient percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.
- B Hospitals who qualify as nominal charge providers under 42 CFR 413.13(f) shall be reimbursed on an interim basis by Medicaid at the lesser of seventy-five percent (75%) of usual and customary charges as billed by the provider for covered services or one hundred percent (100%) of the facility's Medicaid-allowable outpatient cost-to-charge ratio as determined from the most recent desk-reviewed cost report. Reimbursement at the applicable percentage shall be effective July 1 of each SFY for all providers.
- C A hospital which had a change in ownership or merged its operation with another hospital between January 1, 1997 and June 30, 2002, and does not have a 1997 cost report filed by new owner, shall have the option to delay its entry into prospective outpatient payment methodology or enter the prospective outpatient payment methodology identified in subsection I.A. of this regulation. The hospital must notify the Division of its decision by March 3, 2003. A hospital which chooses to delay its entry into the prospective outpatient payment methodology will receive an outpatient payment percentage effective July 1, 2002 in accordance with section II.C.1., and will have final settlements calculated in accordance with Attachment 4.19B Appendix A. The transfer to the prospective outpatient payment percentage will occur as follows:
1. A hospital which does not have a fourth prior year cost report (for SFY 2003 cost report would be 1999) filed by new owner will have its retrospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from the most current desk reviewed cost report, either prior or current owner. All cost reports for prior and current owner ending in the SFY prior to the year the new owner receives a prospective outpatient payment percentage in accordance with paragraph II.C.2., will have a final settlement calculated in accordance with Attachment 4:19B Appendix A, and;

2. A hospital which has a fourth prior year cost report filed by current owner, will have its prospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from its fourth prior year cost report for the fourth and fifth SFY after the change in ownership or merger which occurred prior to July 1, 2002. For the sixth SFY the hospital's rate will be established in accordance with subsection I.A. of this regulation.

Chart for prospective rates for change in ownership or merger:

| 1 st cost report filed calendar year | Settlement calculated | SFY | SFY Prospective rate granted | Cost reports used for Prospective rate |
|---|-----------------------|------|------------------------------|--|
| 1998 | Yes | 1998 | No | |
| 1999 | Yes | 1999 | No | |
| 2000 | Yes | 2000 | No | |
| 2001 | No | 2001 | No | |
| 2002 | No | 2002 | No | |
| 2003 | No | 2003 | Yes | 1999 |
| N/A | No | 2004 | Yes | 1998, 1999 & 2000 |
| N/A | No | 2005 | Yes | 1999, 2000 & 2001 |

- III Closed facilities. Hospitals which closed after January 1, 1999 but before July 2, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with Attachment 4.19B Appendix A.

IV Definitions

- A Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.
- B Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the form utilized in filing the cost report.
- C Effective date.
1. The plan effective date shall be July 1, 2002.
 2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

- I. Outpatient hospital settlements, Provider-Based Rural Health Clinic (PBRHC) settlements or Provider-Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the Division receives the Medicare/Medicaid cost report with a Notice of Provider Reimbursement from the hospital Fiscal Intermediary. Outpatient settlements shall not be determined for cost report periods ending after December 31, 1998 except for recently closed hospitals, new hospitals as provided for in subsection I.E., and nominal charges providers as provided for in paragraph I.E.4.
 - A. The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC/PBFQHC Medicaid payments (except for those hospitals that qualify under subsection I.B., whose payments will be based on the percent of cost in I.A.1., 2, 3 or 4.) for:
 1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection I.D., or eighty percent (80%) of the outpatient charges from paragraph I.C.1.;
 2. Services after January 4, 1994 and prior to April 1, 1998, the lower of ninety percent (90%) of the outpatient share of the cost from subsection I.D., or ninety percent (90%) of the outpatient charge from paragraph I.C.1.;
 3. Services after March 31, 1998, included in cost reports ending prior to January 1, 1999 the lower of one hundred percent (100%) of the outpatient share of the cost from subsection I.D, or one hundred percent (100%) of the outpatient charge from paragraph I.C.1; and.
 4. PBRHC and PBFQH shall be reimbursed 100% of its share of the cost in subsection I.D.
 - B. A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in subsection I.A.1., 2 or 3.
 - C. The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be:
 1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under Attachment 4.19B
 2. For provider based PBRHC and PBFQHC the charges and payments will be services billed under Attachment 4.19B, page 8 for FQHCs and page 44 for PBRHCs.

2. Closed facilities. Hospitals which closed after January 1, 1999 but before July 1, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040(4)(E)1; and
 3. New hospitals which do not have a fourth, fifth, and sixth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three cost report periods.
 4. Hospitals who qualify as nominal charge providers in accordance with 42 CFR 413.13(f) will have final settlements calculated for all cost report periods.
 5. Hospitals which had a change in ownership or merged with another hospital between January 1, 1997 and June 30, 2002 will have a final settlement calculated in accordance with this regulation from the first three cost report periods after the change in ownership or merger after which it will be reimbursed under the prospective outpatient hospital reimbursement methodology unless it elects to be reimbursed under the prospective payment methodology starting July 1, 2002.
- F. The Medicaid PBRHC or PBFQHC final settlement will determine either an overpayment or an underpayment for the hospital's PBRHC or PBFQHC services. For PBRHC or PBFQHC services multiply the PBRHC or PBFQHC Medicaid charges from paragraph (4)(C)2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the PBRHC or PBFQHC payments associated with charges from paragraph (4)(C)2., are subtracted. The difference is either an overpayment (negative amount) due from provider or an underpayment (positive amount) due to provider.
- II Reopened cost reports received after the Division has completed a final settlement will be calculated in the same manner as the original settlement. The Division will not reopen any cost report when the amended NPR is received more than five years after the hospital fiscal year end, unless the reopening is due to the provider submitting false or fraudulent information in its cost report. If the amended cost report changes the previous settlement by less than one hundred dollars (\$100), the cost report will not be reopened.